WHO denounces health benefits of alcohol

Alcohol is not good for health, the World Health Organisation (WHO) declared last week, in response to reports that drinking small amounts of alcohol may prolong life. "We are seeking to demystify advertising that says that alcohol is good for your health, and to debunk the idea that to have a drink a day will keep the doctor away," said Dr Mario Argondona, chief of the treatment unit of the Programme on Substance Abuse at the WHO.

The programme's director, Mr Hans Emblad, warned, "There is no minimum threshold below which alcohol can be consumed without any risk. Alcohol can be blamed for some of the world's most serious health problems. The less you drink, the better."

Mr Emblad disputed the significance of the research published by Professor Richard Doll in the *BMJ* about the cardioprotective effects of a moderate intake of alcohol (8 October, p 911). "There are other ways of reducing the risk of cardiovascular disease: avoid smoking, engage in physical activity, eat less fat," he said.

This view is disputed by Professor Brian Pentecost, medical director of the British Heart Foundation, who said, "There is a very substantial body of evidence now which suggests that moderate consumption of alcohol is associated with a reduction of not only cardiovascular deaths but all causes of death." The WHO is concerned that the publicity given to this evidence may have influenced some people to start drinking.

In its criticism of Professor Doll's paper the WHO claims that there is no indication that drinking more than one drink every other day reduces the risk of cardiovascular disease in comparison with total abstinence. The WHO's stance has raised questions over the recommended safe levels of alcohol intake. "We are not preaching abstinence or teetotalism," reassured Dr Argondona. But he said, "We should be aware that alcohol is a risky, addictive and toxic substance, and that the safe threshold for drinking is culture dependent."

In its statement, the WHO said that "the recommended level of drinking does not take into account body weight and individual vulnerability, the pattern and spacing of drinking or the drinking context."

A spokesperson for the Medical Council on Alcoholism said, "Responsible citizens are bound to ask how much they can drink before they risk harming their health and it is not helpful to refuse to give them any guidelines."

BLACK/IMPACT

Dangerous dining? WHO says that drinking any alcohol is risky

The council recommends retaining the present guidelines that less than21 units a week for men and 14 for women is a "sensible level" of alcohol intake.

In the *BMJ* paper Professor Doll and his colleagues concluded, "The present results provide no evidence for any upward revision, especially as the upper limit in such guidelines may in practice be followed only approximately, human nature being what it is."—NAOMI CRAFT, *BMJ*

Burnley's battle ends in consultants' victory

Consultants at an NHS trust hospital in Lancashire won a long and bitter dispute with management last week when Dr Sam Pickens, the medical director, resigned. He did so after over 50 consultants at Burnley Health Care Trust threatened to pass a vote of no confidence in the trust's board if he did not give up his post. He will return to being a full time consultant physician at the hospital.

Doctors had already passed two votes of no confidence in Dr Pickens—the first in early September, when he was criticised for not consulting them on medical issues. Tension increased at the trust when Mr Ian Mahady, a consultant obstetrician and gynaecologist, was made redundant. On 15 September Mr Mahady, was told by Dr Pickens and David Meakin a senior manager to clear his desk and leave the hospital in three hours. Less than two weeks later consultants passed their second vote of no confidence in Dr Pickens in protest at his involvement in Mr Mahady's departure. At that time the trust's board stood by him.

Dr Pickens's decision to resign follows that of the trust's chief executive, Maggie Aikman, two weeks ago. Mrs Aikman was asked to go by the chairman of the trust, James Rawson, at least partly because of doctors' and patients' anger over Mr Mahady's departure. About 7000 patients signed a petition demanding his reinstatement, and a vigil was held outside the hospital in protest.

According to Peter Forster, the BMA's industrial relations officer for the North West region, the inflexible, macho management style of the trust was inevitably going to lead to conflict. "The incident with Ian Mahady just hastened the process. Management did not communicate with doctors, and there was a lack of involvement with medical staff in drawing up contracts with the main purchasers," said Forster. "The trust did not recognise the local negotiating committee in setting terms and conditions of service for doctors, and there was limited recognition of some trade unions."

The clinical director of surgery had resigned earlier in the year over a dispute with management over lack of junior surgical staff on call.

But Forster says that what galvanised the consultants into action was the manner of Mr Mahady's redundancy. Forster, who as Mr Mahady's representative was at the

Headlines

US abortion doctor's killer convicted: A jury in Pensacola, Florida, has found a former minister, Mr Paul Hill, guilty of murdering a doctor who carried out abortions and an escort. Mr Hill could face life in prison or death in the electric chair.

Italy reports more cholera cases: After more cases of cholera were confirmed in Bari health inspectors have found traces of cholera bacteria in sea water near sewage outlets and on a sample of vegetables in a local market. The last serious outbreak in Italy occurred more than 20 years ago.

Restrictions eased on plague in India: Experts have called for an end to restrictions on passengers departing from India and the medical examination of travellers arriving from India after the limited outbreak of pneumonic plague in Surat.

More attention needed for personality disorders: An inquiry into the killing of a man in Britain by a psychiatric patient with a personality disorder says that the treatment of such people must be reconsidered. The Mental Health Act should be changed to enable patients to be kept in hospital for two or three years.

Alternative measles vaccine sought: The British Department of Health will ask pharmaceutical companies what plans they have for developing an alternative to the combined measles and rubella vaccine after religious leaders expressed concern that the current vaccine is derived from tissue from an aborted fetus.

Italy tightens smoking ban: An Italian draft bill, modelled on legislation in force in other European countries, would prohibit smoking in hospitals, schools, shops, theatres, and restaurants and on public transport.

UK prisoners will have random drug tests: All prisoners in England and Wales will be subject to random drug tests. Eight prisons and young offender institutions will take part in the initial programme, expected to cost £200 000.

Legal parenthood after surrogate birth: Married couples in Britain who have a child born to a surrogate mother have until April 1995 to apply for legal parenthood instead of going through the full adoption procedure. The child must be genetically related to one of the couple.

meeting when managers ordered him out of the hospital in three hours, was astonished by his treatment. "I asked what their reason was," said Forster. "Mahady had done an operating list the day before, and I said that he had patients to see. They told us it was unnecessary—that someone else would see them."

The trust decided in early July that it would have to make someone redundant because it had not met the terms of part of its gynaecology contract with East Lancashire Purchasing Authority—a contract that doctors claim they were not involved in setting up. According to Forster, the trust picked one criterion for selecting which consultant in the specialty should go. Mr Mahady was offered redundancy because he was the consultant with the lowest number of referrals from general practitioners over the past 12 months. Mr Mahady refused to take voluntary redundancy, and since his enforced departure the BMA has lodged a complaint with an industrial tribunal and appealed for his reinstatement to the secretary of state for health. Meanwhile the trust has set up an independent review to investigate the circumstances of Mr Mahady's redundancy.

At the time of Mr Mahady's departure the trust issued a press release saying that he "was offered a...large sum of money in excess of his entitlement." It has been rather less forthcoming about any packages offered to either Dr Pickens or Mrs Aikman. Last week three local members of parliament called for an urgent inquiry into reports that Mrs Aikman had received £250 000. "We are not in a position to comment on Mrs Aikman's settlement," said David Meakin, now acting chief executive. "Legal partners from both sides have drawn up the settlement." Neither Mrs Aikman nor Dr Pickens was available for comment.

In the wake of the resignations the medical advisory committee, chaired by Dr Peter Ehrhardt, a paediatrician, has drawn up a list of proposals to heal the damage. The trust's board has virtually accepted all 12 of them. They include recognition of the local negotiating committee, increased medical representation on the trust's board, clinical input into the drawing up of contracts with purchasers, and a ban on new performance related pay schemes for the trust's board.

"Doctors here have had a disastrous period where morale has been low," said Dr Ehrhardt. "The function of management is to provide an infrastructure so that people at the sharp end have what we need to do our job properly. People bring their children to see me, not the chief executive. Burnley is not unique. The fundamental miscalculation is that everything's done behind closed doors. People don't have to answer to anyone so long as at the end of the financial year the accounts look okay."

James Johnson, chairman of the BMA's Central Consultants and Specialists Committee, said that all trusts should recognise the importance of the situation at Burnley. "It is the patients who will inevitably be the losers when working relationships break down and managers ignore their professional staff."—LUISA DILLNER, *BMJ*

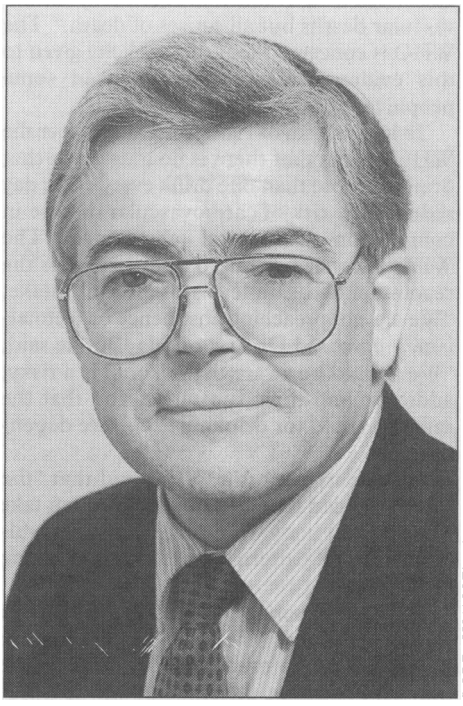
Stroke victim's case highlights legal confusion

The High Court in London has been asked to intervene in a battle over the future of a wealthy stroke victim between his estranged wife and son in Norway and his cohabitee in England. The 75 year old international photographer, named only as Mr S, who suffered a massive stroke a year ago, is being cared for in an English hospital pending the outcome of the wrangle over where he should live.

His estranged wife, from whom he separated in 1945, and his son want him transferred to a nursing home in Norway, while the Englishwoman with whom he has lived for four years wants him to stay in Britain. In a dramatic eleventh hour dash seven weeks ago police turned back an ambulance taking him and his son to East Midlands airport to catch a flight to Norway. His cohabitee, Mrs A, obtained an immediate High Court injunction restraining further attempts to remove him from hospital.

Mr S is paralysed and can communicate only by lifting his thumb. The case raises difficult legal questions about who, if anyone, has the right to decide where he should live and how far the court has power to intervene. The official solicitor, Peter Harris, who has been appointed his guardian for the court case, has asked a consultant psychiatrist to try to determine whether he is mentally capable of taking his own decisions.

Mr S settled in Norway when he married, and he and his wife never divorced, though they have lived apart for nearly 50 years. He began a relationship with Mrs A in 1990 in England. He was put into hospital after the stroke in September last year, but the doctor in charge of his case decided two months ago



LORD CHANCELLORS OFFICE

Peter Harris the official solicitor

that he should be transferred to a nursing home. The doctor contacted the man's wife and son in Norway after being told that he would need to consult the patient's next of kin. After arranging a place at a nursing home in Norway Mr S's son flew to Britain and arrived at the hospital with an ambulance to collect him. The matron, who had not been told of the arrangement, allowed Mr S's son to take him away but had second thoughts and telephoned the police, who turned back the ambulance.

Mrs A is seeking a High Court declaration that it would be in his best interests to remain in Britain. Mrs Justice Hale recently ruled that the court had jurisdiction to give a declaration as to whether any treatment proposed for Mr S would be lawful or not. If he proves incapable of deciding for himself the court will have to decide whether to exercise its jurisdiction.

Previous cases, including the "right to die" case concerning Tony Bland, a victim of the football disaster at Hillsborough, confirm that the courts' powers are limited to declaring whether a particular treatment would be lawful or unlawful. A gap in the law means that neither the court nor anybody else has the right to take decisions about treatment for mentally incapable adults. The Law Commission is expected to make proposals soon to plug the gap. —CLARE DYER, legal correspondent, *BMJ*

Conference urges better housing for better health

A call for more decent housing in Britain and more accessible health services for homeless people has been made by the Standing Conference on Public Health. The conference points to the wealth of evidence linking bad housing and poor health and accuses the government of failing to commit itself to providing adequate resources to improve the problem.

The conference, an umbrella body for 18 health and social care groups, has produced a major report on housing, homelessness, and health, in which it says: "Not only is the health of homeless people put at risk by their living space and their position in the welfare hierarchy, but people with special health and mobility needs are disproportionately vulnerable to becoming homeless in the first place."

Dr Sonja Hunt, a health research consultant and one of the members of the working group behind the new report, said: "As well as the obvious homeless, there are many millions more whose health problems are hidden. They may have a place to live, but it is cold, damp, mouldy, noisy, and insecure—in effect, they are homeless."

Dr Hunt spoke scathingly of the "current preference for blaming all our ills on smoking and sloth" and added: "The increase in life expectancy owes almost everything to improvements in living conditions and almost nothing to medicine."

PREUSS/FORMAT

Unhealthy housing—the poorest conditions are in the private rented sector

The report calls for an intensive programme of renewal of existing housing stock. Peter Archer, divisional director of housing services for Bristol city council, said that there were almost 800 000 homes currently standing empty in Britain, most of them privately owned. He said: "The poorest conditions and the highest rents are in the private rented sector. We need proper controls on the private sector, particularly for houses in multiple occupation. We need inducements and enforcements." Mr Archer said that there was a need for 100 000 new homes every year, but he could not realistically foresee more than 30 000 being provided. He also criticised the current position whereby local authorities were often forced to refuse adaptations to severely disabled people. "That should not be happening," he said.

The report calls on the government to transfer empty government properties to the social housing stock. It also recommends giving local authorities the right to invest in new building schemes the receipts from sales of council houses. One key criticism is the lack of liaison between various government departments. Hence housing benefit is now paid in arrears rather than in advance, which prevents many recipients from living in privately rented accommodation.

Dr Sonja Hunt pointed out that Britain had the highest excess of winter deaths (40 000) in northern Europe. Even Sweden, with far lower winter temperatures, had fewer excess deaths. "The costs of housing are often said by the government to be enormous. But the costs of doing nothing are unthinkable. Scabies and tuberculosis are rising for the first time in 100 years. We have to improve housing now, and no amount of jogging and low fat yoghurt will compensate."—CLAUDIA COURT, *BMJ*

Housing, Homelessness and Health is available from the Nuffield Provincial Hospitals Trust, 59 New Cavendish Street, London W1M 7RD, price £7.

GMC to revise its ethics advice

The General Medical Council in Britain is to revise its advice to doctors on professional conduct and medical ethics by providing guidance that is positive rather than negative. The guidance will also be more explicit and accessible to a wider audience, including the public. Existing guidance is set out in *Professional Conduct and Discipline: Fitness to Practise* (the "blue book"), in the council's annual report, and in separate advice on, for example, HIV infection, confidentiality, and advertising. But the council's standards committee has been increasingly concerned that these were not widely read nor always understood by doctors. The committee's chairman, Sir Donald Irvine, headed a working party that has recommended that the guidance should be recast in a statement on the duties of a doctor, and also in a booklet on good medical practice.

The council has already produced a draft of the statement, which says that doctors must, among other things, respect the rights of patients to be fully involved in decisions about their care and act promptly to protect patients from risk when there is good reason to believe that they or a colleague may be unfit to practise. The statement also advocates keeping professional knowledge and skills up to date, recognising the limits of your professional competence, and ensuring that your personal beliefs do not adversely affect the care or treatment you provide.

The booklet expands on doctors' duties and contains guidance on standards relating to clinical care, maintaining professional relationships with patients and colleagues, and honesty. It also includes a statement of principle relating to the advertising of doctors' services. There will continue to be separate but linked advice on such issues as confidentiality and audit as well as informa-

tion about the council's health and conduct procedures, which will spell out the forms of misconduct that could lead to disciplinary action.

Sir Donald Irvine said: "The best possible care for patients will come from doctors who are self motivated." That was why it was important for young doctors to know what they were committing themselves to when they entered medicine. Some of the guidance in the draft documents had, Sir Donald pointed out, been borrowed from the nursing profession.

"This is the most important initiative the council has taken," Dr James Appleyard, a consultant paediatrician in Canterbury, said. "But we will get it right only if we have adequate consultation and people have a strong sense of ownership." Council members are asked to submit comments on the drafts, and the council hopes to approve final versions of the documents on the duties of a doctor and on good medical practice at its meeting next May. Sir Donald Irvine agreed to take on board the suggestions that the statements should include doctors' responsibilities for education and training and that doctors had to provide effective care within available resources.—LINDA BEECHAM, *BMJ*

UPPA

Mr Reagan : his confession may increase his credibility

Alzheimer's society welcomes Reagan's "bravery"

The former American president Ronald Reagan has taken the unprecedented step of sending a handwritten letter to the American people revealing that he is suffering from Alzheimer's disease. His action has been welcomed in Britain by the Alzheimer's Disease Society as "a brave decision."

Mr Reagan is the first person of such international repute to admit publicly to suffering from Alzheimer's disease, and his letter is being hailed as a great boost to the campaign to remove the stigma from mental illness. In the US attitudes towards stigmatising illnesses are more open than they are in Britain, as witnessed by the comprehensive publicity surrounding the treatment for alcohol dependency of Betty Ford, the wife of another former American president, Gerald Ford.

In Britain attitudes are less far advanced. Clive Evers, assistant director of the Alzheimer's Disease Society, said: "Mr Reagan's statement is a sign of the progress that has been made in public understanding and acceptance of the nature of Alzheimer's disease in recent years. There is still some reticence in the United Kingdom for public figures to acknowledge the disease, but we believe Mr Reagan has made a major contribution towards the elimination of any remaining stigma that may still be associated with it."

The Alzheimer's Disease Society hopes that Mr Reagan's action will heighten awareness of the condition worldwide. Clive Evers said: "The experience of Mr Reagan and his family will be similar to that of 630 000 people with dementia in the United Kingdom. The individual and the family will need increasing help and support over time with this progressive and ultimately fatal condition."

But while Mr Reagan's courage has been praised by many, there are some who fear that the former president was such a figure of ridicule during his time in office that he may not be an appropriate or helpful figurehead to publicise the disease. Clive Evers disagrees: "There was always an element of lack of full credibility in his presidential career, but the comics and the satires reflected that, rather than the medical condition which he has now made known. We feel that his experience of the disease is separate and distinct from his political career."—CLAUDIA COURT, *BMJ*

Merck offers money back guarantee on finasteride

Merck, the American drug manufacturer, is offering a money back guarantee with finasteride (Proscar), its new drug treatment for benign prostatic hyperplasia. The company is offering to refund the cost of the drug if it fails to improve symptoms within six months or if the patient needs prostatic surgery within two years.

Finasteride is an antiandrogen, prescribed by general practitioners and urologists, which inhibits the metabolism of testosterone, reducing the volume of prostatic tissue and improving urinary flow rates in men with benign prostatic hyperplasia. It is the only drug of its class and, according to Mr David Kirk, a consultant urologist at the Western Infirmary, Glasgow, offers an alternative to prostatectomy for some men. "I don't think there would be any problem about offering a money back guarantee on these kind of drugs," he said. "Some men do extremely well on treatment, but a significant minority don't improve at all. On the other hand, most of these men are being treated for their symptoms so any subsequent assessment of benefit is bound to be largely subjective."

The public affairs manager at Merck's headquarters in the US, Mr Michael Seggev, said that patients had to comply with treatment at least three quarters of the time for the offer to hold. "Assessment is based on an established symptom score chart filled in by the patients. If the score has not gone down, by even one point, after six months of treatment the money is refunded. This applies to all patients taking the drug as long as they have moderate or severe symptoms," he said. Symptoms should improve quickly after the start of treatment, but it takes up to six months to establish that improvements are directly due to the drug.

The offer was introduced earlier this year to boost flagging sales, and, according to Merck, uptake has been promising. So far 30 Veterans Administration hospitals and 11 private health maintenance organisations have joined the scheme. "It's too early to know what the return rate will be," Mr Seggev said, "but on the basis of trial results we expect nine out of 10 men to show some improvement." A six month course of finas-

teride costs over $280 (£185). The company does not expect to repeat the offer for any of its other products.

The company's operation in Britain, Merck Sharpe and Dohme, says that it has no plans to introduce a money back scheme in Britain, but Mr Vincent Lawton, the managing director, said that it would be a good way of ensuring that drug treatments were used effectively. "It is a terrific waste of resources when medicines are not used properly, with inadequate doses and poor compliance and in inappropriate cocktails with other medicines. This would be a guarantee of efficacy and a real sharing of risk with real effects if promises are not kept," he said.—ALISON TONKS, *BMJ*

France tightens up controls on foreign doctors

The French government is planning new laws to stop the influx of "foreign doctors" (médecins étrangers) into the country and to ban those already working from taking private patients. Nearly 8000 of the 180 000 doctors in France are foreign doctors; they may, however, be French nationals—the term applies only to where they got their degree. Many of them qualified in north Africa and the Middle East, and more than half of them have acquired French nationality.

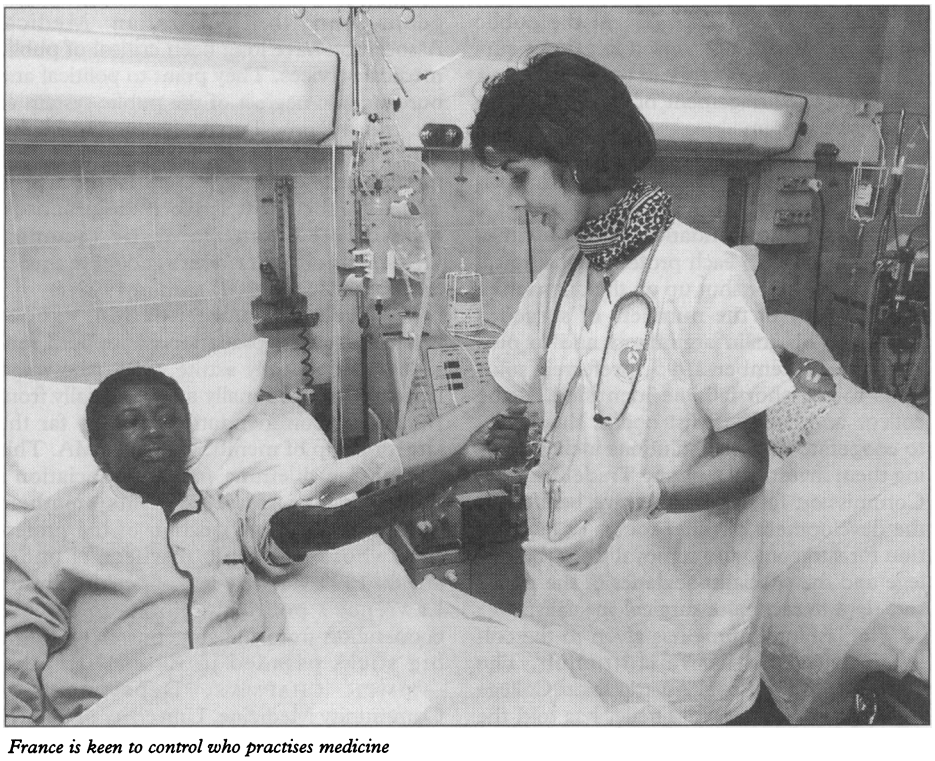
Such doctors do not have the same rights as French doctors who studied in France. Most foreign doctors work in public hospitals for low salaries and under supervision. They are not wanted in the private practice market, not only because they might edge out French doctors with French degrees but also because they are needed to fill the undesirable on call jobs that French graduates try to avoid—such as internships in anaesthetics, obstetrics and gynaecology, and general surgery in public hospitals.

Last month Professor Paul Malvy raised the question of foreign doctors before the National Academy of Medicine, which is one of the members of the commission that grants—or refuses—foreign doctors' applications to practise in France. Malvy noted that 20 years ago about half of the 400 foreign doctors who asked to practise in France were accepted after taking examinations but that last year the number of candidates increased to 1800 while the rate of acceptance fell to 5%.

Malvy suggested two solutions to the problem of foreign doctors. One would be to accept qualified foreign doctors for hospital practice only, so that they do not compete with French doctors in private practice. He recognised that this solution might seem shocking, because it would create a category of doctors permanently deprived of the right to private practice. The alternative would be to grant foreign doctors the right to practise in whatever way they wished, but only after about 10 years of hospital practice.

A few days after Malvy's question foreign doctors were also discussed at a regular interministerial meeting. The ministers opted to improve the status of foreign doctors by improving their job security but still barring them from private practice. They proposed all but closing the door to newcomers who want to settle in France, which would particularly affect the increasing number of Algerian doctors who, faced with violent political unrest at home, are applying for work in France.

If such a measure is adopted by parliament it will not apply to doctors from countries in the European Union, whose degrees are recognised in France. These doctors can practise freely wherever they want within the European Union.—ALEXANDER DOROZYNSKI, medical journalist, Paris



ARKELL/IMPACT

France is keen to control who practises medicine

Russia proposes testing foreigners for AIDS

A bill that would require all foreigners entering Russia to be tested for AIDS has provoked opposition from human rights activists but has been welcomed by some doctors. Only three members of the 450 seat Duma, the lower house of parliament, voted against the bill, which was passed after a stormy debate on 28 October.

Condemning AIDS as a disease imported from abroad, deputies agreed measures that would require every foreigner—even tourists and businesspeople on short visits—to carry proof that they were not infected with HIV. Those who are HIV positive or refuse to be tested would face deportation. The bill also makes life tougher for Russian citizens by introducing compulsory testing for AIDS for those entering some professions, such as surgery. To become law the bill must now go through the upper house, the federation council, and pass a final reading in the Duma. President Boris Yeltsin has a right of veto but is unlikely to use it.

Years of relative isolation from the outside world ensured that levels of HIV infection in the former Soviet Union remained well below levels in the West, which created the image of the disease as one confined to foreigners, especially Africans. But recent figures from the Russian AIDS centre have confirmed the country's low position in the European league tables: an estimated 112 people have died of AIDS since 1987, and 815 people are infected with HIV. But experts have put the true number of people who are HIV positive at closer to 10 000 and have warned that compulsory testing would create a false sense of security.

Vadim Pokrovsky, a leading specialist in AIDS, has criticised the law on the grounds that it would be expensive and would divert funds away from education programmes. Some foreign experts, such as Kevin Gardner, cochairperson of Moscow's AESOP AIDS education centre, has been more forthright. "It is just a way for the Russian government to pretend that it is doing something about AIDS in the country, when in fact it is not doing very much at all," he said.

The influential daily newspaper *Izvestia* has also alleged that several doctors who spoke out in favour of the bill had links with companies that produce kits for HIV tests. Although the newspaper provided no proof, the accusation rings true in a country where most doctors are poorly paid and forced to seek other forms of income.

Even so, some members of the Russian medical community say that crisis measures are needed to combat the spread of HIV before it is too late. "It is not the most effective way to fight AIDS, but we have to start somewhere," said Galina Perfiliyeva, dean of the nursing faculty at Moscow's Sechenov Medical Academy.

How the law would be implemented is not clear. Immigration controls at Russia's airports are already hopelessly overloaded. It could also hit hard at tourism and Russia's

attempts to encourage business links with the West. Those opposed to the measure also point to the precedent of the 1989 law ordering compulsory AIDS tests for any foreigner staying in the then Soviet Union for three months or more: few if any people were ever tested.—PETER CONRADI, Moscow correspondent of the *European*

Dutch pharmacists revamp their image

The Dutch pharmacists' organisation has launched a 17 million guilder (£6.2m) campaign to increase the profession's profile and emphasise its role in the health care system. The three year campaign aims at encouraging people to turn to dispensing chemists for advice about medicines. Backed by a series of television advertisements about medicines and their use, the campaign aims at dispelling the image of the pharmacist as a well paid glorified shop assistant. According to the association's research, half the customers who had used the same pharmacy for more than five years did not know what their dispensing chemist looked like.

The campaign comes at a time when chemists, the drug industry, and wholesalers are under increasing government pressure to cut the national drugs bill, which is currently more than five billion guilders (£1.8bn) a year. The pharmacists' association points out that though the national drugs bill may be high the prescription rate is low. According to the health ministry, one in three of the population had a prescription from their doctor in 1993—a far lower rate than in countries such as France and Italy. One reason that the drugs bill is so high, says the pharmacists' association, is that medicine is so expensive—according to some estimates 48% above the European average. It wants manufacturers and wholesalers to be forced to cut their prices.

Dispensing chemists, facing increasing competition from alternative methods of drug delivery, such as mail order, and proposals to allow supermarkets to sell over the counter preparations, are now trying to persuade the government to firm up legislation that will allow them to substitute named drugs with generic drugs more frequently.

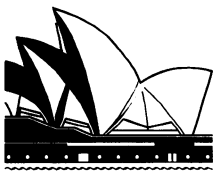
"Currently one in three named drugs is substituted by the pharmacist with its generic alternative," said Voituron. "That brings in savings of 100 million guilders (£37m) a year. We want to make it two in three in three years' time."

Under current laws dispensing chemists are allowed to substitute generic versions of prescribed drugs after consultation with the patient and doctor. The health ministry is now considering two reports that suggest that the pharmacist could choose which drug to give.

The national general practitioners' association accepts the need to stimulate the use of generic drugs but is strongly opposed to this becoming compulsory. "Introducing market forces and more competition does not fit within the concept of care," said spokesman Hans Witmer. —ROBIN PASCOE, freelance journalist, Amsterdam

Focus: Sydney

Australian surgeons savaged by cutting report



Against a backdrop of rising health care costs, politically damaging concern about surgical waiting lists, and a media ever ready to frame stories about doctors in terms of medicine-gone-wrong, Porsche driving, and general self interest, the Australian federal health minister for human services and health, Dr Carmen Lawrence, in June this year commissioned a major inquiry into the surgical workforce.

The report, *A Cutting Edge: Australia's Surgical Workforce 1994*, was delivered last month by its author, Peter Baume, a gastroenterologist who is professor of community medicine at the University of New South Wales. Baume served for 17 years as a Liberal senator in the Australian federal parliament. As a liberal "wet" he championed welfare and health reforms in both government and opposition before quitting politics when the Liberal party turned neo-Thatcherite in the late 1980s. Since then he has served as a bipartisan consultant to several governments, furthering his reputation as a creative egg cracker in medicopolitical cake baking. And the cake of long waiting lists and spiralling costs needs the cracking of an emu sized egg: the mutually beneficial collusion between the private hospital system and many surgical specialists.

Baume's 181 page report highlighted what he saw as:

- The excessively tight controls exercised by the Royal Australasian College of Surgeons on the supply of surgeons—overall, in nearly all specialties, in rural areas, and in the numbers of women being trained
- A future where, by 2001, there would be a shortfall in surgeons in Australia ranging from 26% in plastic surgery to 85% in urology
- Delays in elective surgery in the public hospital system being caused largely by surgeons' reluctance to work in public hospitals and their encouragement of patients to use the private system
- The historical deskilling of general practitioners in routine minor surgery and investigation.

His 98 recommendations started with a frank challenge to each professional surgical body to put up or shut up on the question of the accuracy of the numbers of surgeons central to his main arguments and to provide, by September 1995, preferred solutions to the shortfalls he identified. If the college and the specialist bodies should fail to cooperate Baume's solutions include having them investigated by the Trade Practices Commission for anticompetitive behaviour, the development of other routes of registration for surgeons, and removal from the college and the specialist societies of the exclusive right to recognise surgical specialists.

The lashing Baume has given to the college of surgeons has raised tumult. The President of the Royal Australiasian College of Surgeons, Dr David Theile, has told the department of health, "It's inconceivable that [the college] could perceive any of the proposed changes are sustainable," arguing that quality of care to patients would be compromised. The general practitioners' college has responded with enthusiasm to the surgical reskilling recommendations—providing, of course, they are accompanied by appropriate rewards. The college of surgeons and the Australian Medical Association have long been critical of public medical services. They point to political and bureaucratic neglect of the public system as the true villains. Baume has endorsed this concern, but he points out that "perverse" funding arrangements for specialists, in concert with their restrictive trade practices, have created some fantastic incomes. Otolaryngologists averaged just under $A500 000 (£250 000) each in 1992-3.

Baume's recommendations about reskilling general practitioners are both sensible and politically astute. GPs, who stand to benefit professionally and financially from Baume's recommendations, are by far the largest group of members in the AMA. This will pose a dilemma for the association's twin concerns: to serve all its members while defending any section of the profession whose economic privilege is under attack. 1995 will be a test of health minister Lawrence's political abilities to achieve cooperation from the surgeons or wield the big sticks paraded in Baume's report. —SIMON CHAPMAN, Department of Community Medicine, University of Sydney